

November 23, 2015

Lynette Mason
4115 Smith Dr
Spencer OK 73084-8929

State Farm Claims
PO Box 106171
Atlanta GA 30348-6171

RE: Claim Number: 36-7L60-727
 Date of Loss: November 04, 2015
 Our Insured: Lyndee Harrison

Dear Lynette Mason:

This will acknowledge receipt of your claim for this loss. I am the claim representative handling this third party liability claim. All future correspondence relating to the claim under this coverage should be directed to my attention. This letter should not be construed as an acceptance of liability.

To expedite the handling of your injury claim, an Authorization for Release of Information is enclosed. This signed authorization will allow me to obtain the needed information to evaluate your claim. In addition, please supply a list of all medical providers that treated you for your injuries. If a wage loss claim is involved, furnish the name and address of your employer(s).

Please forward the following documentation regarding your claim:

Name, address and phone number of your **medical providers**. Name, address and phone number of your **employer**. Name, address, phone number, and claim number of the **auto carrier** providing PIP benefits.

If you have any questions, please contact us.

EXHIBIT 21

HARRISON-01256

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Sincerely,

Valencia Allen
Claim Specialist
(844) 292-8615 Ext. 337
Fax: (855) 820-6318

State Farm Mutual Automobile Insurance Company

Enclosure(s): Return Envelope
Authorization to Provide Information
Provider/Employer Information

HARRISON-01257

Provider/Employer Information

This form is to be completed by the injured party (parent or guardian if the injured party is a minor).
(Please use back of form if needed).

Claim Number: 36-7L60-727		Injured Party: Lynette Mason		Date of Birth: 10/15/1967	
TREATING FACILITY / PHYSICIAN					
Name of Facility / Physician:			Still Treating? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates of Treatment:
Address:			Telephone Number:		
City:	State:	ZIP Code:	Fax Number:		
TREATING FACILITY / PHYSICIAN					
Name of Facility / Physician:			Still Treating? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates of Treatment:
Address:			Telephone Number:		
City:	State:	ZIP Code:	Fax Number:		
TREATING FACILITY / PHYSICIAN					
Name of Facility / Physician:			Still Treating? <input type="checkbox"/> Yes <input type="checkbox"/> No		Dates of Treatment:
Address:			Telephone Number:		
City:	State:	ZIP Code:	Fax Number:		
HOSPITAL					
Name of Hospital:				Taken by Ambulance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:					
City:	State:	ZIP Code:	Fax Number:		
EMPLOYER (Complete if wage loss claim is being presented)					
Name of Employer:		Dates missed from work:	Hours per day:	Hourly wage:	
Address:					
City:	State:	ZIP Code:			
H. R. Contact or Supervisor:		Telephone Number:	Fax Number:		
HEALTH INSURANCE CARRIER					
Name of Insurer:			Claim Number:		
Policyholder Name:			Policy Number:		
Insurer Address:			Insurer Phone Number:		
City:	State:	ZIP Code:	Insurer Fax Number:		
OTHER INSURANCE CARRIER (Disability, Automobile, Medicare/Medicaid, Workers Compensation)					
Name of Insurer:			Claim Number:		
Policyholder Name:			Policy Number:		
Address:			Insurer Phone Number:		
City:	State:	ZIP Code:	Insurer Fax Number:		

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Authorization for Release of Information

NOTE: Property and Casualty insurance is excluded from the definition of "health plan" in the privacy rules developed pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is not a covered entity. However, this authorization meets the core elements criteria set forth in the HIPAA privacy rule, Section 164.508 (c).

Name of Injured Person: Lynette Mason (herein after referred to as the "Injured Person")

Date of Birth of Injured Person: October 15, 1967
(needed to locate records)

State Farm® Claim Number: 36-7L60-727

I authorize:

- (1) any medical, psychological, psychiatric, osteopathic or chiropractic physician, dentist, any other medical practitioner or healthcare provider, hospital, clinic, rehabilitation facility, nursing home, or any other healthcare facility to disclose information from the medical and healthcare records of the Injured Person. I understand that the specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other information including any history, treatment records, diagnosis, prognosis, narrative reports, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans and other information; and
- (2) any firm, employer, or insurance company to furnish information about the earnings, loss of earnings, work history, workers compensation claim, and other medical information in its/their possession concerning the Injured Person, as well as, Event Data Recorder (EDR) information, photographs and other information about the physical damage to the vehicle(s) involved in the accident; and
- (3) any educational organization to furnish the school records of the Injured Person to; State Farm Mutual Automobile Insurance Company, its subsidiaries and affiliates, its claim associates, and legal representatives (hereinafter referred to collectively as "State Farm").

I authorize the use of the above information to permit State Farm to investigate, process, and determine the amount payable, if any, for all claims made under any State Farm property and casualty insurance policy that applies to the accident or occurrence on November 04, 2015.

I understand as part of the claim handling process, State Farm may disclose medical or other information obtained by this authorization to physicians, dentists, other medical or healthcare providers or other professionals for their review and professional opinion. This information may also be released to other insurance companies for their use in connection with insurance transactions, or as required or permitted by law. Information obtained pursuant to this authorization may later be redisclosed and may not be protected under the HIPAA privacy rule. I understand that I may refuse to authorize disclosure of all or some of the requested information, but that refusal may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claim(s).

This authorization may be revoked at any time, except to the extent that State Farm has taken action in reliance on this authorization prior to notice of revocation. Such revocation must be in writing, dated, signed, and include the claim number referenced above. I understand that revocation of this authorization may potentially cause a delay in processing, or result in the denial of, insurance benefits for the pending injury claims(s).

This authorization is valid for the duration of the claim referenced above, and a photocopy is as valid as the original. This authorization specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and signed this document as a free and voluntary act for the purposes noted above. I understand that I may obtain a copy of this authorization upon written request submitted to State Farm.

Date: _____

Signature of individual or personal representative

Description of personal representative's authority or relationship to patient

Provide the last four digits of the Social Security Number of Injured Person:

(REQUIRED TO LOCATE RECORDS)

10/28/2014

HARRISON-01259